Edith M. Barreira, LMFT
Marriage & Family Therapist

Solutions Mental Health LLC

Date: _____

Client First Name: _____

Client Last Name: _____

D.O.B.: _____ Age: _____

Address: _____Apt.#: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home/Work Phone: _____

Email: _____

Electronic Notification: __ Email __ Text Messaging

(By selecting the check boxes, the patient agrees to receive text and email notifications from the practice)

Relationship Status:
( ) Single ( ) Married ( ) Partnered ( ) Divorced ( ) Widowed ( ) Other: _____

Race:
( ) American Indian ( ) Black African American ( ) Asian ( ) White ( ) Hispanic ( ) Other

Employment:
( ) Employed ( ) Unemployed ( ) Full-Time Student ( ) Part-Time Student ( ) Retired
( ) Other

Primary Language: _____

Referred by: _____

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Relative to Contact in Case of Emergency

First Name: _____ Last Name: _____

Primary phone: _____

Relationship to Patient: _____